Office of Minority Health

Minority Health Disparities in Nebraska

2004 Fact Sheet

FROM THE ADMINISTRATOR OFFICE OF MINORITY HEALTH

Most people in Nebraska enjoy a relatively healthy and good quality of life as their life expectancy and overall health continues to improve. However, for racial and ethnic minorities in Nebraska, good health is elusive as there continues to be significant disparity in their overall health and quality of life.

The Office of Minority Health (OMH) represents and advances the interests of people of color for the purpose of reducing the health disparity existing between racial/ethnic minorities and non-minorities in Nebraska.

Since the establishment of the OMH in 1992 it has become increasingly apparent that health care professionals, community advocates, and consumers must develop effective ways of meeting the challenges presented by our rapidly changing and culturally diverse society. Although Nebraska as a whole enjoys a relatively healthy and good quality of life, the health status of the state cannot be at its best when racial and ethnic minorities continue to experience poor health.

Health reports and data fact sheets are important tools with which to effectively assess and then improve the quality of health status of all residents in Nebraska. This document shows there still exists notable health disparities among Nebraska racial and ethnic minority groups. As the quality of available data continues to improve, the support of racial and ethnic minority communities, along with government and private agencies, is needed now more than ever before to close these existing gaps, reduce disparities and improve health standards.

We thank you for your support in the processes designed to reduce health disparities and urge you to use this information in your organization's planning, implementation, and evaluation of health programs across Nebraska.

"The success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health; the state's paramount concern should be the health of its people."
~ Franklin Delano Roosevelt

NEBRASKA MINORITY HEALTH DISPARITIES

The *Nebraska Minority Health Disparities Fact Sheet* is formatted to provide a user-friendly summary of data providing capstone highlights of selected minority health indicators and issues. All issues and health indicators included are vital as they provide bench marks upon which Nebraska minority health status and disparities are constantly gauged. This fact sheet provides a selected highlight of particular issues in minority health. However, the September 2003 *Health Status of Racial and Ethnic Minorities in Nebraska Report* contains a comprehensive discussion of both the socioeconomic determinants as well as various indicators or causalities of health disparities in Nebraska, profiling the most important health statistics, maps, tables, figures and charts.

The information and data presented in this Fact Sheet are derived from various sources of the Nebraska Health and Human Services System as well as national resource materials. All rates included are age-adjusted to the 2000 U.S. population standard. Caution should be exercised while interpreting, analyzing and/or using data herein as some may have been based on small numbers.

This Fact Sheet was developed by Onyema G. Nkwocha, Program Analyst with the OMH, and valuable contributions from staff members of Office of Minority Health, the Nebraska Health and Human Services System Data Management, and DAS Print Shop. Special thanks to Cindy Harmon and Carliss Moore for formatting and review.

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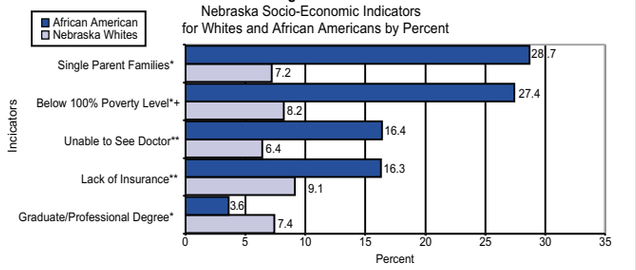
AFRICAN AMERICANS

Context

In Nebraska, African Americans number 68,541, comprise 4% of the state population, and are the second largest ethnic group (behind Hispanics), according to the U.S. Census 2000. The majority of African Americans live in the cities of Omaha, Lincoln, and Bellevue, as well as in Sarpy County. [1]

Figure 1
Nebraska Socio-Economic Indicators
for Whites and African Americans by Percent



* U.S. 2000 Census: (*+ Percent Below 100% Poverty level for a family of four was $17,603 in 2000);
** NE BRFSS 1998-2002
Source: NE HHSS BRFSS 1998-2002 and U.S. 2000 Census

Poverty rates indicate that African Americans are 3.3 times more likely to live in households with incomes below 100% of the federally-designated poverty level as compared to Nebraska whites.

About 16.3% of all African Americans in Nebraska are without health insurance. Furthermore, in the past year, 16.4% could not see a doctor when needed to because of the cost (Figure 1).[2]

Historically, individually permeated and institutionalized racism, racial and discriminatory practices, along with social and economic inequities may explain, to some degree, differential and disproportionate health outcomes for African Americans.[3] Nevertheless, in the last decade, encouraging progress has been made in improving the quality of health and health outcomes for African Americans.

However, both racism and unequal health treatments continue to exist. The Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, indicates that not only do health disparities exist, but African Americans and other "racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors such as patients' insurance status and income are controlled." [3]

Other national studies found that African Americans are treated less aggressively for pain, are offered limited cardiovascular procedures and little prenatal care technology than others of similar socioeconomic status. Thus suggesting that race impacts the quality, appropriateness and timeliness of care received by African Americans. [4]

COMMUNITY HEALTH ISSUES IN PERSPECTIVE

Community concerns regarding health issues and disparities among African Americans in Nebraska include:

- Cardiovascular/Heart Disease
- Cancer
- Diabetes
- Overweight and Obesity
- Infant Mortality
- Teen Pregnancy and Single Parenting
- HIV/AIDS/STDs
- Access to Health/Lack of Insurance
- Poverty
- Preventive Education

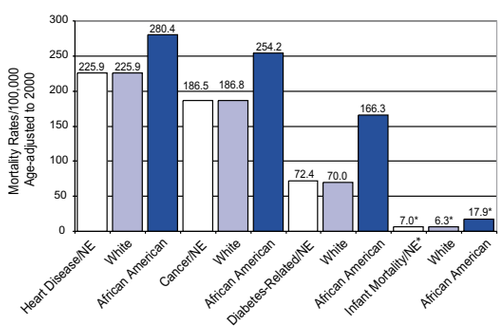
Where are the Concerns?

Overall, minority and low-income populations have a disproportionate burden of death and disability from CVD. African Americans have the highest rate of high blood pressure of all groups and tend to develop it younger than others [5] Studies have shown that socioeconomic status, reflected in income and education, underlie a substantial portion, but not all, of the higher rate of heart disease in minority populations.[6]"

1998-2002 FINDINGS

- One-fifth of African American adults (20.5%) rated their health status as either "fair" or "poor," compared to 12.3% of white Nebraskans.[2]
- African Americans continue to report a higher prevalence of obesity (31.5 %) and cigarette smoking (19.2 %) than whites (20.6 and 17.0 %). Prevalence of no leisure time physical activity for this group (31.6 %) was higher than the rate for whites (27.0 %).[2]
- The incidence rate for AIDS among African Americans (50.5) is 11.2 times the white rate. African Americans are also 5.3 times as likely to die of AIDS as whites in Nebraska.[2]
- Heart disease (532 deaths) and cancer (500 deaths) were the number one and two leading causes of death among African Americans in the five-year period 1998-2002.[2]
- The age-adjusted mortality rates from heart disease (280.4 deaths/100,000), is 1.2 times greater than the white rate, making African Americans more likely to die from the disease than whites.
- Cancer mortality rates (the number of deaths per 100,000 population) are higher among African Americans (254.2). African Americans in Nebraska are more likely to develop cancer than any other racial or ethnic group and are 1.4 times more likely to die of the disease than whites are (Figure 2).[2]
- Mortality rates for strokes (89.5/100,000), and diabetes-related causes (166.3/100,000) among African Americans also increased in the current five-year period. African Americans are 1.6 times as likely as white Nebraskans to die from strokes and 2.4 times as likely to die from diabetes-related causes.[2]
- Infant mortality (17.9/1,000 live births) was 2.8 times higher for African Americans than whites in Nebraska during 1998-2002.
- 17% of African American infant deaths under one year of age, are due to Sudden Infant Death Syndrome.
- The low birth weight rate (129.1/1,000 live births) for African Americans was double the rate for the white Nebraskans.
- In 1997-2001, the incidence rate of AIDS in Douglas County was 7.7/100.000, compared to Nebraska's 4.5, while the incidence rate of STD's was 668.9 compared to Nebraska's 302.5/100,00.[2]
- The teen fertility rate for African Americans was 95.8 births per 1,000 live births during 1998-2002. This was almost three times as high as the rate for white teenagers (34.6).[2]

Figure 2
Nebraska Selected Health Indicators
for African Americans and Whites 1998-2002



* Rates per 1,000 Live Births
Source: Nebraska Health and Human Services System, Vital Statistics

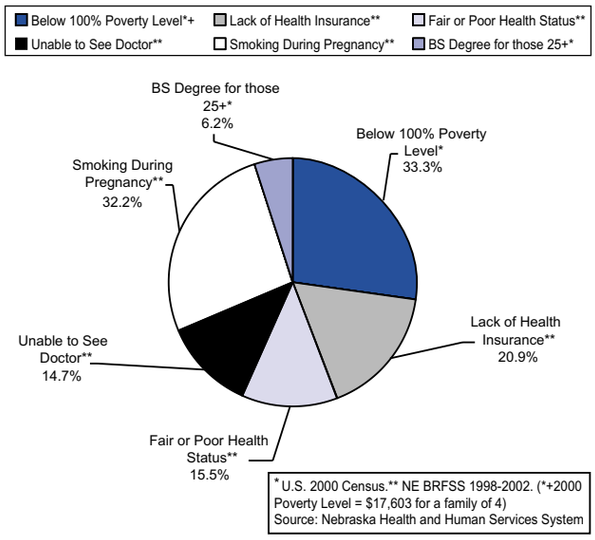
NATIVE AMERICANS

Context

The historical impact on Native Americans of European expansion in North America is all well known and documented.[7]

In Nebraska, Native Americans number 14,896 or 0.9% of Nebraska's total population, according to the U.S. 2000 Census.[1] As part of the President's Initiatives on Race, the Indian Health Service (IHS) is working on an Initiative to Eliminate Racial and Ethnic Disparities in Health.[8] The IHS is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indian and Alaska Native people. It comprises 12 regional administrative units called Area Offices,[9] one of which is the Aberdeen area office that provides services to Nebraska Native Americans. Receiving IHS medical services is dependent on a Native American proving that he/she is an eligible member of one of 557 federally recognized tribes in the US. They must present an identification card, and must reside in a designated IHS service area.[4]

Figure 7
Selected Risk & Socio-Economic Factors
for Native Americans



* U.S. 2000 Census.** NE BRFSS 1998-2002. (*+2000 Poverty Level = $17,603 for a family of 4)
Source: Nebraska Health and Human Services System

IHS is focused on the six health areas of infant mortality, diabetes mellitus, cardiovascular disease, HIV/AIDS, breast and cervical cancer screening, and child and adult immunization.[5] The 2000 poverty rate among Native Americans in Nebraska is 33.0%, 20.9% have no health insurance, and 14.7% were unable to see a doctor because of cost (Figure 7).[2]

What are the Concerns?

Native Americans are several times more likely to have type 2 diabetes as whites of similar age:

- In Nebraska, Native Americans are 3.5 times, and are 4.9 times as likely to die of diabetes and diabetes-related issues, as well as 2 times more likely to die of heart disease as whites are.[2]
- Rate of unintentional injuries was 107.7/100,000 while motor vehicle fatality rate was 43.6/100,000 and cigarette smoking rate, 14.2%.[2]

COMMUNITY HEALTH ISSUES IN PERSPECTIVE

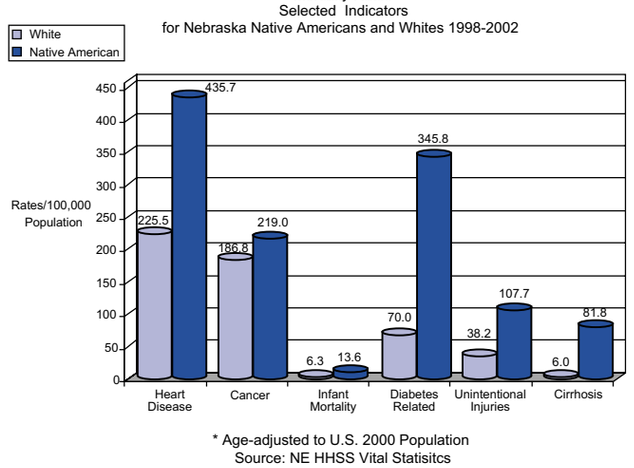
Community concerns regarding health issues and disparities among Native Americans in Nebraska include:

- Access to Health/Lack of Insurance
- Poverty
- Preventive Education
- Infant Mortality
- Cardiovascular Disease/Heart Disease
- Diabetes Mellitus
- HIV/AIDS
- Deficits in Breast and Cervical Cancer Screenings and Management
- Child and Adult Immunization
- Cirrhosis of the Liver
- Obesity and Overweight
- Physical Inactivity
- Motor Vehicle Accidents/ Unintentional Injuries
- Chemical and/or Substance Abuse

1998-2002 FINDINGS

- Life expectancy, a general indicator of health status, is 67.9 years for all Native Americans, 65.6 for men, and 70.1 for women.[2]
- The proportion of Native American adults who rated their health status as either "fair" or "poor," was 15.5%, compared to 12.3% of white Nebraskans. (Figure 7)[2]
- During 1998-2002, 20.9 percent of Native American adults 18 and over, reported having no health insurance. By the same token, 14.7% self reported that they were unable to see a doctor due to cost in the past 12 months.[2]
- The percent of Native American mothers who received first trimester prenatal care slightly increased to 65.8% for 1998-2002 from 64.1% in 1993-1997.[2]
- With a death rate of 435.7/100,000, heart disease is the leading cause of death among Native Americans.
- The infant mortality rate for Native Americans has increased by nearly 53.0% from the previous five-year period rate of 8.9 to a 1998-2002 rate of 13.6 deaths per 1,000 live births.[2]
- 14% of all Native American infant deaths under one year of age are due to birth defects (1998-2002).[2]
- Native Americans have experienced an increasing mortality rate due to heart disease (435.7/100,000). Relative risk of death due to heart disease is 1.9 times the white rate. (Figure 7A)[2]
- Native Americans report the highest mortality rate (81.8/100,000) due to cirrhosis of the liver than any other racial/ethnic group in Nebraska. The relative risk of mortality is 13.8 times.[2]
- Native Americans reported the highest rate of diabetes-related deaths (345.8 per 100,000) of any racial/ethnic group in the state. Rates have increased and are now 4.9 times the rate for white Nebraskans.[2]
- The death rate in the Native American community was 219.0 per 100,000; and Native Americans are 1.2 times more likely to die from cancer than whites. Approximately 14% (13.6%) of all infant deaths were caused by birth defects (Figure 7A).[2]
- "Alcohol takes a disproportionate toll among Native Americans. An overall indicator of this toll is that Native Americans have a higher rate of alcohol-related death than the general U.S. population. This is especially true in the under-45 age group. For example, in the age group 25-34, Native American men die 2.8 times more frequently than non-Indian men from motor vehicle crashes, 2.7 times more from other accidents, 2.0 times more from suicide, 1.9 times more from homicide, and 6.8 times more frequently from alcoholism (alcohol dependence syndrome, alcoholic psychosis, chronic liver disease, and alcoholic cirrhosis)." [14]

Figure 7A
Mortality Rates*
Selected Indicators
for Nebraska Native Americans and Whites 1998-2002



* Age-adjusted to U.S. 2000 Population
Source: NE HHSS Vital Statisitcs

ASIAN AMERICANS

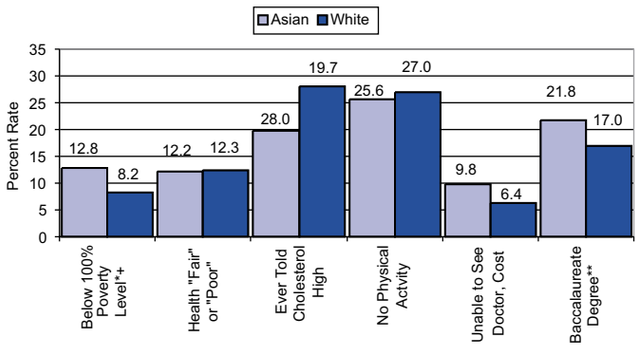
Context

"The Asian/Pacific Islander (API) population is the fastest growing group in the United States. Between 1980 and 1997, this population grew from 3.5 million to 10 million persons,"[11] according to the Kaiser Permanent Diversity Council. Asian/Pacific Islander Americans include Japanese, Chinese, Korean, Filipino, South Asian (East Indians, Pakistanis, Sri Lankans, Guamanians, Fijians, Paulaunans), Southeast Asians (Vietnamese, Thai, Cambodians, Laotians, Hmong, Mien), as well as Indonesians and Malaysian populations.

With more than 82% of their children living in families with both parents, Asian Americans believe in a cohesive family as 64% of adult members of this group live in married-couple families compared to 55% in the U.S. Across the nation, 42% of Asian Americans 25 years and above have four or more years of college, compared to 25% of whites, 13% of African Americans, and 10% of Latinos.[11]

In Nebraska, the U.S. Census 2000 data indicates that Asian Americans comprise 22,767 or 1.3% of the state's total population. With growth in population, come comparable health disparities. "The alteration in diet has placed Asian and Pacific Islander Americans at a higher risk than their respective Asian counterparts to diseases attributed to dietary factors. Such diseases include, coronary heart disease, colorectal cancer, stroke, non insulin-dependent diabetes mellitus and arteriosclerosis," according to Kaiser Permanent.[11] Approximately, 12.8% of Asian Americans in Nebraska live in households below 100% of the federally defined poverty level,[1] while 16.9% have no health insurance (Figure 3).[2]

Figure 3
Selected Nebraska Socio-Economic and Risk Factors
for White and Asian Americans 1998-2002



*+ (Percent Below 100% Poverty level for a family of four was $17,603 in 2000, U.S. 2000 Census),
**Percent of Persons 25 Years and older, U.S. 2000 Census Source: NE HHSS BRFSS 1998-2002 and U.S. 2000 Census

COMMUNITY HEALTH ISSUES IN PERSPECTIVE

Community concerns regarding health issues and disparities among Asian Americans in Nebraska include:

- Poverty [2]
- Cardiovascular disease/Coronary heart disease
- Stroke
- Colorectal Cancer
- Non insulin-dependent diabetes mellitus
- Obesity
- Diabetes Mellitus II
- Gallbladder Disease
- Substance Abuse
- Racism [11]

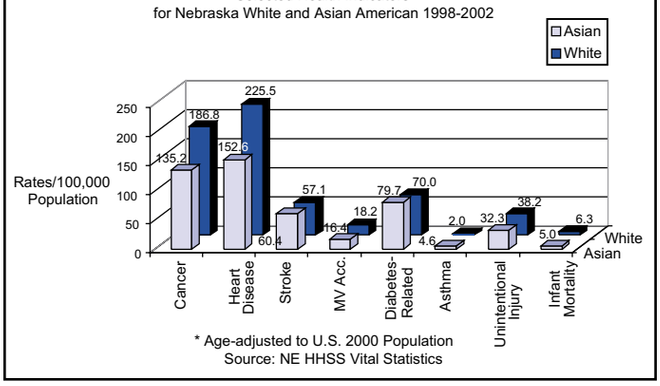
Where are the Concerns?

Asian Americans have a disproportionate burden of poverty (12.8%), lack of insurance (16.9%), an increasing substance abuse, heart disease (152.6/100,000), cancer (135.2/100,000) and diabetes-related (79.7/100,000) mortality rates when compared to whites. Close to one-third (30.7%) of all Asian American infant deaths was attributed to birth defects. [2]

1998-2002 FINDINGS

- Approximately 17 percent (16.9%) of Asian Americans self-reported they have no health insurance, according to the Nebraska Behavioral Risk Factor Surveillance System, 1998-2002.[2]
- The proportion of Asian Americans who were ever told their cholesterol level was high in the past 5 years was 28.0% compared to 19.7% for whites. (Figure 3) [2]
- About 10.6% of Asian American mothers self-reported that they received inadequate prenatal care in 1998-2002, based on the Kotelchuk index, compared to 9.0% of white mothers in Nebraska.[2]
- The proportion of Asian American adults who rated their health status as either "fair" or "poor," was 12.2 percent compared to 12.3% of white Nebraskans.[2]
- Although the incidence rate of sexually-transmitted disease among Asian Americans decreased by 60.0% in the period 1998-2002 when compared to the previous five-year period, it is still 1.4 times the rate for whites in the state.[2]
- Although Asian Americans (152.6) had lower rates than whites, this group experienced a substantial increase (102.6%) in heart disease mortality rate (from the rate of 74.0/100,000 in 1993-1997) (Figure 4).[2]
- In the five-year period 1998-2002, cancer was the leading cause of death among Asian Americans (135.2). In the same period, cancer was the second leading cause of death among African Americans, Native Americans, and white Nebraskans.[2]
- The mortality rates due to unintentional injuries among Asian Americans was 32.3/100,000 during 1998-2002. This rate indicates a 129.0% increase from the previous rate of 14.1/100,000 during the period 1993-1997.

Figure 4
Mortality Rates*
Selected Health Indicators
for Nebraska White and Asian American 1998-2002



* Age-adjusted to U.S. 2000 Population
Source: NE HHSS Vital Statistics

- Motor Vehicle mortality increased by 173.3% from the rate of 6.0/100,000 during the previous period 1993-1997 to 16.4/100,000 during the current five-year period, 1998-2002 (Figure 4).[2]
- Asian Americans recorded an increase of 310.8% in diabetes-related mortality rates, from 19.4/100,000 in 1993-1997 to 79.7/100,000 during 1998-2002. This sharp increase may have been due in part to better reporting and coding of race in the second period 1998-2002.

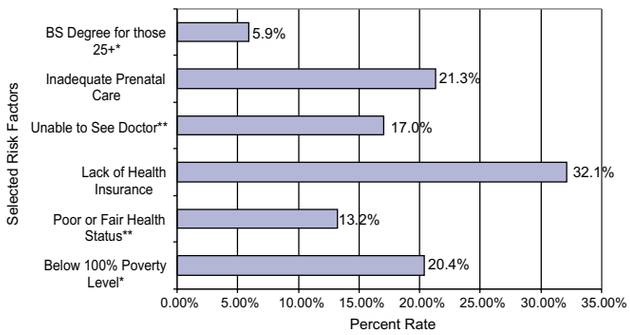
The population of the Asian American community in Nebraska increased by about 83.3 percent from 12,422 in 1990 to 22,767 in 2000 – U.S. Census 2000.

HISPANIC AMERICANS

Context

In Nebraska, the largest minority group is now the Hispanic/Latino population, which accounts for 5.5% of the state's total population. A substantial amount of growth in population occured from 36,969 in 1990 to 94,425 in 2000 (a 155.4 percent increase!)[2] Although the population of the U.S. increased by 13.2% from 1990 to 2000, in the same period, the Latino population increased by 58% having grown from 22.3 million to 35.3 million. The terms "Hispanic," "Chicano," "Latino/Latina," are used to aggregate several distinct populations of Hispanic origin.[12] When there is no "distinction made to highlight 'Latinas,' then the term 'Latino' will generally refer to both men and women." "Latino" and "Latina" are now used interchangeably by the U.S. Government with or since the 2000 Census.[2] Hispanics exhibit an example of heterogeneity of people coming from different nations and cultures. The U.S. 2000 Census catalogues the following Hispanic subgroups according to proportions: Mexican American (58.5%), Puerto Rican (9.6%), Central American (4.8%), South American (3.8%), Cuban American (3.5%), and all other Latino or Hispanic American (19.8%).[12]

Figure 5
Selected Risk & Socio-Economic Factors
for Hispanic Americans 1998-2002



*U.S. 2000 Census. ** NE BRFSS 1998-2002. (+* 2000 Poverty Level = $17,603 for a family of 4).
Source: Nebraska Health and Human services System

With growth in population, come comparable disparities. The poverty rate from the U.S. 2000 Census indicates that 20.4% of Hispanic Americans in Nebraska, which is more than double the rate for white (8.2 percent) Nebraskans, live in households below the 100% federally designated poverty level. During 1998-2002, 32.1% of adult Hispanic Americans in Nebraska had no health insurance, compared to only 9.1% of white Nebraskans (Figure 5). Approximately 17.0% (16.5%) of Hispanic adults state they were unable to see a doctor at some time in the past twelve months because of the potential cost of care, and 13.2% self-rated their health as being "fair" or "poor," compared to 11% of whites. In like manner, 58.0% reported going for a routine checkup in the last 12 months.[2]

COMMUNITY HEALTH ISSUES IN PERSPECTIVE

Community concerns regarding health issues and disparities among Hispanic Americans in Nebraska include:

- Access to Care/Lack of Insurance, "Latinos face significant barriers that limit their access to health care services. Compared to the general population, they are the least likely to have access to a regular source of health care and the most likely to underutilize available health care services." [12]
- Language Barrier: "When Latinos have access to health care services, many are limited-or non-English proficient and need bilingual health care providers and/or (interpreter) translated documents." [12]
- Discrimination
- Poverty/Education/Low-Paying Jobs
- Cancer/Heart Disease/Diabetes
- Gallbladder Disease/Cirrhosis of the Liver
- Inadequate Prenatal Care/Infant Mortality
- Unintentional Injury Mortality and Homicide [2]

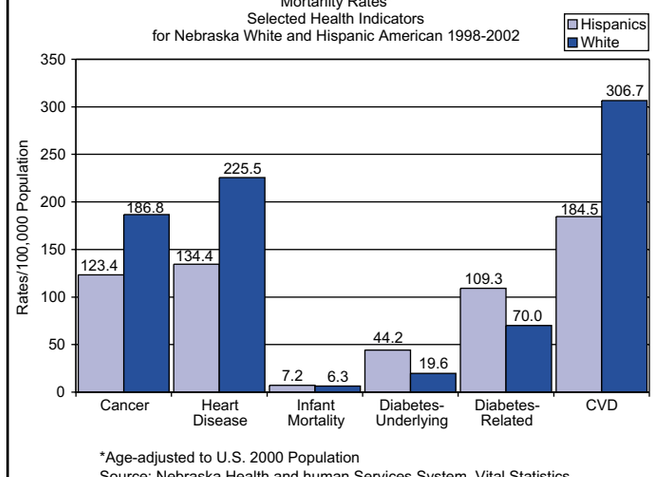
1998-2002 FINDINGS

- Close to one-third (32.1%) of adult Hispanics have no health insurance, and 17% self-reported they could not see a doctor because of cost. (Figure 5)[2]
- A little over one-fifth (21.3%) of Hispanic American mothers reported receiving inadequate prenatal care, according to the Kotelchuk Index, compared to 9.0 % of white mothers in Nebraska.[2]
- Only 58% reported going for a routine checkup in the last 12 months.[2]
- During 1998-2002, cancer was the leading cause of death among Hispanics at rate of 123.4 per 100,000,[2] followed by heart disease.
- Prevalence rates for cigarette smoking for Hispanic Americans (16.0%) is somewhat side by side with the rate for white Nebraskans. However, Hispanics experienced higher rates for obesity (22.0%), no leisure-time physical activity (35.6%), and nonuse-of-seatbelts (25.9 %).[2]
- Prevalence of binge (20.0 %) and heavy drinking (8.4 %) among Hispanic Americans were higher than the rates for white (17.6) and (4.8%) Nebraksans.[2]
- The prevalence of asthma among Hispanic Americans 18 years of age and older was 4.7% according to the combined results of the Nebraska 1999-2001 Behavioral Risk Factor Surveillance System.[2]
- 25% of all Hispanic infant deaths during 1998-2002 were caused by birth defects, while 10.4% died of Sudden Infant Death Syndrome (SIDS), compared to 27.9% and 12.7% for white infants.[2]
- The heart disease mortality rate for Hispanics was 134.4/100,000, a 3.1% increase from the rate of 130.4 during the previous five-year period 1993-1997 (Figure 6).
- Hispanic Americans experienced a 21.7% decrease in infant mortality, thus making Hispanic infants 1.1 times as likely as white infants to die within their first year of life.
- Diabetes-related deaths ranked third behind heart disease and cancer as the leading cause of death among Hispanic Americans (109.3/100,000) (Figure 6).

Where are the Concerns?

Hispanic Americans have a disproportionate burden of poverty, (20.4%), lack of insurance (32.1%), substance abuse, (binge drinking (20%), fertility rates for age 15-19 (110.7/1,000 live births), heart disease (134.4/100,000), cancer (135.2/100,000) and diabetes-related mortality rate (109.3/100,000) and stroke mortality rates when compared to whites.[2]

Figure 6
Mortarlity Rates*
Selected Health Indicators
for Nebraska White and Hispanic American 1998-2002



*Age-adjusted to U.S. 2000 Population
Source: Nebraska Health and human Services System, Vital Statistics

1998-2002 STATEWIDE FINDINGS

PERCENTAGE GROWTH IN MINORITY POPULATION

Table 1
Growth in Nebraska's Population
By Racial and Ethnic Group*
1990 vs. 2000

	1990	2000	Percent Change
Nebraska Total	1,578,385	1,711,263	8.4
White	1,480,558	1,533,261	3.6
African American	57,404	68,541	19.4
Native American	12,410	14,896	20.0
Asian American	12,422	22,767	83.3
Hispanic American	36,969	94,425	155.4
Total Minority	**119,205**	**200,629**	**68.3**

* Racial and Ethnic Minority populations do not include the number of those who checked more than one race on the census forms.
SOURCE: 2000 U.S. Census and 1990 U.S. Census Data

Table 1 indicates that Nebraska racial and ethnic groups are growing in population. Altogether, in the decade 1990-2000, racial and ethnic minorities have grown by 68.3%, from 119,205 to 200,629. Racial and ethnic minority groups now comprise 12.7% of Nebraska's population, up from 7.5% in 1990. [2]

Table 2
Growth in Nebraska's Population
2000 Population vs. 2002 Population Estimates
and Percent Change by Race and Ethnic Origin

	2000 Population	2002 Population Estimate	Percent of Total Population Estimate	Estimated Percent Growth/ Change (2000 v 2002)
Nebraska Total	1,711,263	1,729,180	100*	1.0
White	1,533,261	1,594,647	92.2	4.0
African American	68,541	72,079	4.2	5.2
Native American	14,896	16,288	0.9	9.3
Asian American	22,767	27,623	1.6	21.3
Hispanic American	94,425	103,594	*	9.7
Total Minority	**200,629**	**231,675**	**13.4**	**15.5**

*Hispanic can be of any race and is already counted among whites, African Americans, Native Americans and Asian Americans. However, the "Other" Category and "Multiple Race" Category (not shown on this table) in the Nebraska population make up 1.1%, which, when added to white, African, Native and Asian American would total 100%.
SOURCE: U.S. Census Bureau: Population Estimates, 2002

Table 2 shows that according to the U.S. Census Bureau, the U.S. Bureau's 2002 population estimates indicate that the population of Nebraska has grown by only one percent. The estimates now show that Nebraska racial and ethnic minorities make up 13.4% of Nebraska's total population, haven grown by 15.5% from 200,629 in 2000 to 231,675 in 2002. Although the proportion of Asian Americans in Nebraska is estimated to be 1.6% of the total population, the 2002 estimate shows that Asian Nebraskans are the fastest growing community in the state. Hispanic Americans (9.7%) and Native Americans (9.3%) recorded the next highest projected growth, while African Americans (5.2%) and whites (4.0%) experienced the least growth among the racial and ethnic groups in Nebraska.

HEALTH INDICATOR FINDINGS

1. Life Expectancy

The average life expectancy at birth for the U.S. was 76.9 years, and 78.2 years in Nebraska, in 2000. In Nebraska, life expectancy at birth was 78.3 years for both genders and 75.6 years for men and 80.7 years for women in 2001.[2]

2. Cardiovascular Disease (CVD) /Heart Disease

Cardiovascular disease (CVD) is the leading cause of death in Nebraska among all genders and African and Native Americans. Coronary heart disease, a sub-division of CVD, also continues to be the leading cause of death in Nebraska, causing a total of 26.9% of all deaths in 2002 (4,235). A higher percentage of African Americans, (29.4%), 22% of Native Americans and a little over 11% each of both Asian and Hispanic Americans indicate ever being told their blood pressure is high compared to whites. When both age and gender are being controlled, the 1998-2002 data indicate that Native Americans (435.7/100,000) and African Americans (280.4/100,000) die from coronary heart disease at a much higher rate than whites (225.5/100,000) (Figure 8).[2]

3. Cancer

Generally, cancer is the leading cause of death among Asian and Hispanic Americans. However, African Americans (254.2/100,00) have the highest cancer death rates, as well as in lung, prostate, colorectal and breast cancer death rates when compared to the white population. For all cancer sites, Native Americans (219.0/100,000) have the second highest cancer death rate, followed by Asians (135.2) when compared to the rate for whites. Only 77.3% and 64.5% of Hispanic and Asian women had a Pap Test in the past two years. Lack of screening and early detection contributes to the higher cancer mortality rates among racial and ethnic groups.[2]

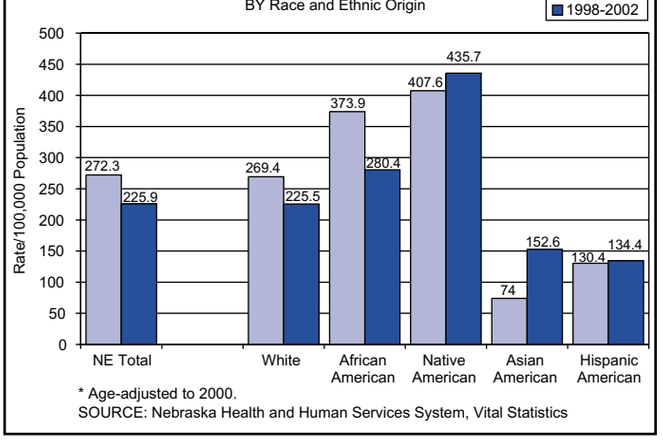
4. Infant mortality

Infant mortality rates among racial and ethnic minorities varied: African Americans (17.9) Native Americans (13.6), Asian Americans (5.0), and Hispanics (7.6) per 1,000 live births. Low birth weight rates as well as the rate of mothers receiving inadequate prenatal care varied among the groups, and were higher when compared to whites.[2]

5. Unintentional injuries

Native Americans are 2.8 and 2.4 times more likely than whites and the general population to die of unintentional injuries and motor vehicle accidents. In both instances, Native American females are 3.0 and 3.2 times more likely than their male counterparts to die from both risk factors.[2]

Figure 8
Heart Disease Mortality Rates*
BY Race and Ethnic Origin



* Age-adjusted to 2000.
SOURCE: Nebraska Health and Human Services System, Vital Statistics

1998-2002 STATEWIDE FINDINGS CONTINUED

6. Homicide

The homicide rates for both Native Americans and African Americans are very high. Native Americans are 10.2 times, while African Americans are 10 times more likely to die from violent and abusive behavior in comparison to whites.[2]

7. Diabetes

Self-reported prevalence of diabetes data shows that 11.4% of African Americans, 6.4% of Hispanics, 4.6% of Asian Americans and 4.1% of Native Americans have been told they have diabetes. Lack of physical exercise and the presence of obesity may be contributing factors to diabetes. The relative risk of diabetes-related death for Native Americans was approximately 5 times higher than the white rate.[2]

8. Cirrhosis of the Liver

Although the cirrhosis death rate has increased by 14.5 percent for Nebraskans overall, among Native Americans in Nebraska the 1998-2002 mortality rate due to cirrhosis (81.8 deaths per 100,000 population) represents a 13.8 percent increase from the 1993-1997 rate of 71.9 deaths per 100,000 population. Native Americans were 13.6 times as likely as white Nebraskans to die from cirrhosis of the liver during the latest five-year period.[2]

9. HIV/AIDS

Although minorities make up only about 12.7 % of the population of the state, 31.0% of the cumulative AIDS cases through 2002 occurred among minorities. In 2002 alone, of the 4,372 new AIDS cases reported, African Americans accounted for 40 percent, Hispanics 10 percent and Asian Americans, less than 4 percent, while whites accounted for 47.0%. Among African Americans, the average rate of new HIV and AIDS cases in 1998-2002 was 50.5, up 25.0% from the previous five-year period. The HIV/AIDS rate for African Americans is 11.2 times higher than the rate for whites in Nebraska (Figure 9).[2]

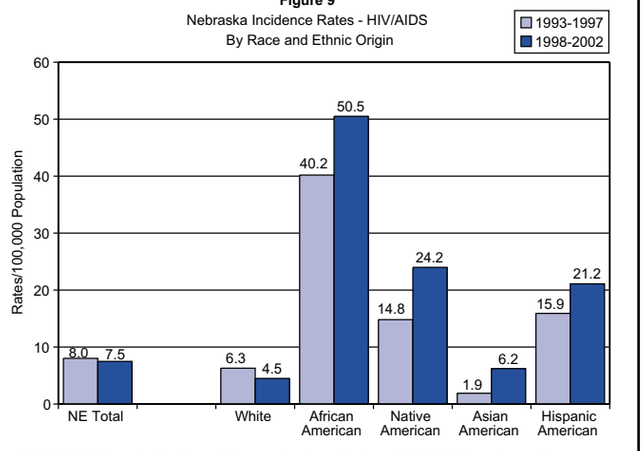
10. Asthma

In Nebraska, during 1998-2002, 218 people died from asthma at an age-adjusted rate of 2.4 deaths per 100,000 people. Of the total, 195 asthma deaths occurred among whites at the rate of 2.0, while 20 of the deaths were among African Americans at a high rate of 7.7 deaths per 100,000 population. In Douglas and Sarpy Counties, from 1987 through 1999, asthma was the cause of death for 238 resident deaths at an average of 18 deaths per year. Of those, 185 (77.7 percent) were white and 52 (21.8 percent) were African Americans. The asthma death rate in these two counties was consistently higher than both the Nebraska and U.S. rates from 1987 through 1998. Douglas and Sarpy Counties experienced a 27.0% increase in asthma deaths from 1990 to 1998 while the national rates remained relatively stable.[2]

11. Immunization

Overall, across Nebraska, 58.0% of adults 65 years and older, reported receiving a Pneumonia shot during 1998-2002. Slightly more than 60.0% of Hispanic Americans, 54.0% of Native Americans, 52.9% of African Americans, and 34.0% of Asian Americans reported they had received a vaccination for pneumonia in the last 12 months compared to 60.3% for whites. Racial and ethnic minority senior citizens are less likely to have had a flu shot.

Figure 9
Nebraska Incidence Rates - HIV/AIDS
By Race and Ethnic Origin



SOURCE: Nebraska Health and Human Services System, HIV/AIDS Surveillance Program.

1998-2002 STATEWIDE FINDINGS: KEY HEALTH DISPARITIES AND ISSUES OF CAUSALITY

"Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities…Disparities in the healthcare delivered to racial and ethnic minorities are real and are associated with worse outcomes in many cases, which is unacceptable…The real challenge lies in developing and implementing strategies to reduce and eliminate them," [13] according to Alan Nelson, Chair of the Institute of Medicine Committee on Confronting Racial and Ethnic Disparities in Healthcare. Added to the above task is the challenge of fully comprehending the many complex factors associated with health disparities. These factors are categorized in groups as follows: Individual Behavioral Risk Factors (IBRF),[3] Socioeconomic Factors, Access to Health Care Services, Quality of Health Care,[7] and Existence of Quality Health Data for Decisions Affecting Health.

1. INDIVIDUAL BEHAVIORAL RISK FACTORS

Individual behavioral risk factors contributing to disparities in health can be categorized as preventable – those over which the individual has some control. These include regular or annual screenings for all kinds of health issues, annual check-ups, lack of physical activity, unhealthy eating, the use of tobacco or smoking,[13] alcohol, and sexual life choices.

2. SOCIOECONOMIC FACTORS

Socioeconomic factors include measures of income, wealth, education, poverty level, occupation and variables such as employment, access to care/transportation[7], marital status, and can impact health.

- Uninsured/Underinsured

  With continuous increase in the cost of healthcare across the nation, access to employer-provided health insurance options dwindles and affects minorities adversely, thus compelling many to forego needed preventive health care services. Many racial and ethnic minority groups are enrolled in state programs such as Medicaid and State children's insurance programs as alternatives.

- Rate of Unemployment

  Historically and as is prevalent today, "unemployment disproportionately affects minority communities. Rates of unemployment, in both good and bad economic times, are consistently higher in minority communities." [7]

- Poverty

  Poverty plays a very adverse role in the perpetuation of health disparities among minorities as it affects not only the affordability of insurance coverage, but also access to quality health, quality food selection as well as overall quality of life choices. Compared to whites, poverty is more prevalent among minorities with 33.3% of Native Americans, 27.4% of African Americans, 20.4% of Hispanics, and 12.8% of Asians living below 100% of the federally mandated poverty levels.[1]

- Education

  Educational attainment and quality thereof show variations among Nebraska racial and ethnic minority communities and the majority population. Education is a predictor of employability, financial status[7] and overall quality of life and health status. In Nebraska, among persons 25 years and older, 33.7% of Native Americans, 31.2% of African Americans, 21.3% of Hispanics, 17.1% of Asian Americans, and a total of 25.5% of all Minorities graduated with a High School Diploma in 2000 compared to 31.8% of whites, according to the U.S. 2000 Census.[1]

3. ACCESS TO HEALTH CARE SERVICES

Access to care is a basic necessity and requirement in the provision of adequate health care services. "As it is a starting point for quality care, equity in this domain is critical. " [7] Grouped under this category include the following:

- Regular Place of Care and Regular Provider, along with follow-up relationship with provider can ensure receipt of appropriate quality care.[7]
- Adequate Insurance Coverage is lacking among racial and ethnic minorities in Nebraska. Thus 32.1% of Hispanics, 20.9% of Native Americans, 16.9% of Asian Americans and 16.3% of African Americans, have no health insurance.[2]
- Compared to whites, language barriers and inadequate interpretation of services, as well as inadequate transportation systems, do negatively impact on health disparities among racial and ethnic minorities.

4. QUALITY OF HEALTH CARE SERVICES

One approach to measuring quality of care is to compare whether minority populations receive more or less care than that of the majority population for certain diseases or conditions, according to IOM's report and other federal studies.[7] To date, no such study has been conducted or performed in Nebraska.

OFFICE OF MINORITY HEALTH CONFERENCE 2003: COMMUNITY PERSPECTIVES

For more than a decade now, the Office of Minority Health has conducted an annual Minority Health Conference which draws a variety of participants from across Nebraska, the Midwest and the nation. One of the purposes of the conference is to increase the awareness of health disparities faced by racial/ethnic minorities, as well as providing an environment for discussing strategies and approaches to eliminate the disparities. To improve the quality of future conferences, 2003 conference participants were asked to fill out survey questions to this effect: *"Are there any topics you'd like to see at future conferences? Please list." and "Do you know of an important Minority Health Issue needing public policy attention or action? Please List."* Below is a partial list of what was gleaned from the survey:

- Creating behavioral health services that are culturally sensitive & appropriate.
- As a minority, how do I cope with a racist environment at work?
- Internalized racism/oppression; oppression of ourselves & our own people.
- During the education & training of future health professionals, how may the educational institutions or communities prepare healthcare professionals in the actual and realistic process of reducing health disparities?
- How public health ties into non-health entities.
- Mental health in African-Americans.
- Issues that Western Nebraska Native Americans face.
- The do's & don'ts of different cultures (cultural norms).
- Addressing issues regarding minorities with developmental disabilities.
- Second-hand smoke & its impact.
- Teen pregnancy & infant mortality.
- Prevention of Substance abuse.
- Cancer.
- Diabetes.
- Maternal Child Health with minorities.
- Culture specific social behaviors, beliefs, etc.
- Mechanisms in place that encourage or mandate healthcare professionals to treat patients fairly.
- More attention on minority elderly, their health & communication challenges they face.
- Continue effort to regulate translation services.
- More money is needed to help minority students get their health professional education. More money is needed for special programs and students. More money is needed for up to date technology for students.
- Mental health in minority communities, especially Hispanic/Latino communities.
- Continue increasing the quality of credentialing requirements for professionals, particularly health care professionals.

POLICY IMPLICATIONS

- Basically, effective policies and decisions positively impacting on the health of all citizens will naturally rely on the availability of accurate and reliable data. As Nebraska is geared toward the elimination of health disparities following both the national and state 2010 health goals and the U.S. Surgeon General's position on zero health disparities between minorities and whites, the need to continue maintaining an effective data tracking system cannot be overemphasized. Availability of accurate and reliable data helps in understanding the current status of health needs as well as in knowing when improvement has been made in the health status of Nebraska's racial and ethnic minority communities. Critical attention and focus on the reduction of disparities in the health indicators identified here as well as the many more not listed, can prove to be one of the effective ways of disparity reduction.

To continue meeting the challenges of attaining the 2010 health goals and elimination of disparities, there should be:

- Continued consistency in the collection and effective use of relevant data, and the reporting of race and ethnicity where applicable.
- A concerted effort in the development of a tracking mechanism or registry in order to ascertain a better picture of the incidence or prevalence of all diseases affecting all Nebraska residents.
- The development of a unique policy guiding the use, reporting and analysis/application of "small number statistics" as it relates to racial and ethnic minorities.
- An intensified effort in the ongoing training and education of bi-lingual and bi-cultural medical interpreters.
- A closer look at the need and possibility of initiating a statewide cultural competency training for all health care professionals, and provider-agencies, might be considered.
- Training more minorities in research, medicine and allied health professions is another option that has not been fully utilized in disparity reduction efforts.
- As the increase in racial and ethnic minority population continues in Nebraska, addressing disparities in health care across the state needs to be a continued priority.
- Using data to understand the disparities existing among the racial and ethinic groups and how the component factors impact on the individual patient, the provider, the health care community and the agencies making policies, the disparity gaps can begin to be closed and improvement in the health of all Nebraskans made.

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